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Care Groups:
A Reference Guide for Practitioners

July 2016

The Technical and Operational Performance Support (TOPS) Program is the USAID/Food for Peace-funded learning mechanism that generates, captures, disseminates, and applies the highest quality information, knowledge, and promising practices in development food assistance programming, to ensure that more communities and households benefit from the U.S. Government's investment in fighting global hunger. Through technical capacity building, a small grants program to fund research, documentation and innovation, and an in-person and online community of practice (the Food Security and Nutrition [FSN] Network), The TOPS Program empowers food security implementers and the donor community to make lasting impact for millions of the world's most vulnerable people.

Led by Save the Children, The TOPS Program draws on the expertise of its consortium partners: CORE Group (knowledge management), Food for the Hungry (social and behavioral change), Mercy Corps (agriculture and natural resource management), and TANGO International (monitoring and evaluation). Save the Children brings its experience and expertise in commodity management, gender, and nutrition and food technology, as well as the management of this 7-year (2010–2017) US$30 million award.

Disclaimer:

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Contents

Acknowledgements ..... **v**

Introduction **1**

What are Care Groups? 1
Purpose of the Care Groups Reference Guide 1

Care Group Essentials **2**

Key Terms and Definitions 2
Care Group Structure 3
Care Group Criteria 4

Establishing Care Groups **9**

Identifying Beneficiary Households 9
Selection of Care Group Volunteers 10
An Alternative Approach to Identifying Beneficiary Households and Electing Care Group Volunteers 11
Formation of Care Groups 11
Selection of Promoters 11

Implementation of Care Groups **13**

Formative Research and Development of Behavior Change Modules 13
Training of Promoters 14
Care Group Meetings 15
Facilitation Cues 17
Household Visits and Group Meetings with Neighbor Women 18

Supervising Care Group Activities **19**

Supportive Supervision 19
Supervision of Care Group Volunteers by Promoters 19
Supervision of Promoters by Project Staff 19
Quality Improvement Verification Checklists (QVIC) 20

Monitoring and Evaluation **22**

Monitoring and Reporting 22
Registers 22
Key Performance Indicators 25
Evaluation 25

Sequencing Care Group Activities **26**

Conclusion **27**

References **28**

Recommendations for Further Reading **29**

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[1]Food Security and Nutrition Network Social and Behavioral Change Task Force. 2014*. Care Groups: A Training Manual for Program Design and Implementation*. Washington, DC: The Technical and Operational Performance Support Program.

Introduction

What are Care Groups?

A Care Group is a group of 10 to 15 community-based volunteer health educators who regularly meet with project staff for training and supervision. They are different from typical mothers' groups in that each volunteer is responsible for regularly visiting 10 to 15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. The Care Group methodology has contributed to improvements in maternal, child health, and nutrition outcomes in a variety of settings.[2]

Purpose of the Care Groups Reference Guide

As with any intervention, the achievement of successful outcomes is dependent on the implementation methodology. The purpose of this guide is therefore to assist Care Group implementers to administer Care Group activities with reasonable fidelity to global standards, in order to achieve maximum impact.

This guide assumes the reader already has a general understanding of the Care Group methodology. It is highly recommended that all Care Group implementers familiarize themselves with the contents of the *Care Groups: A Training Manual for Program Design and Implementation,* and, ideally, to participate in an in-person training on Care Groups, before commencing Care Group activities.

This guide is meant to serve as a companion to the Care Group Training Manual; and additional details on all topics covered in this guide are provided in the Training Manual.

This guide may also be used by program evaluators, as a means to assess the extent to which Care Groups were implemented in accordance with the evidence-based model and their potential contribution to program outcomes.

[2]Readers interested in a detailed description of the Care Group methodology and evidence of its effectiveness should refer to the Recommendations for Further Reading section on page 29.

Care Group Essentials

Since its invention in 1995, more than 25 organizations in nearly 30 countries have implemented the Care Group methodology. The degree to which organizations adhere to the original components of the model has varied, however. In some situations individuals and organizations have defined Care Groups as "any group where you are teaching mothers" or "any group where you are teaching people to teach other people." Wide variations in what is considered a "Care Group" by various agencies could lead to misunderstandings about the methodology and the use of less effective strategies.

This section therefore provides an overview of Care Groups' essential structure and criteria. While each project will adapt the model based on the context (e.g. human resources available, urban vs. rural location, participation of Ministry of Health actors, etc.), it is expected that all Care Group interventions will be faithful to the overall structure and criteria described below.

Key Terms and Definitions

Over the years, organizations have given different names to the various facets of the people and groups within the model. The table below provides suggested terms and a definition for each actor, as well as notes on common adaptations.

Table of Roles, Terms, and Definitions

Term	Description
Care Group	A group of 10 to 15 Care Group Volunteers led by a Promoter.
Care Group Volunteer	Volunteers who meet with the Promoter during Care Group meetings. (Also commonly referred to as "Lead Mothers.")
Promoter	A community member hired to train and supervise the Care Group Volunteers in their community. Several Care Group programs train volunteer community members as Promoters. While organizations report positive results from this practice, the effectiveness of using volunteer Promoters (vs. hired Promoters) has not been tested.
Supervisor	Program staff hired to directly supervise and train Promoters in each community and to monitor the Care Group program.
Coordinator	Hired to directly supervise Supervisors and monitor the Care

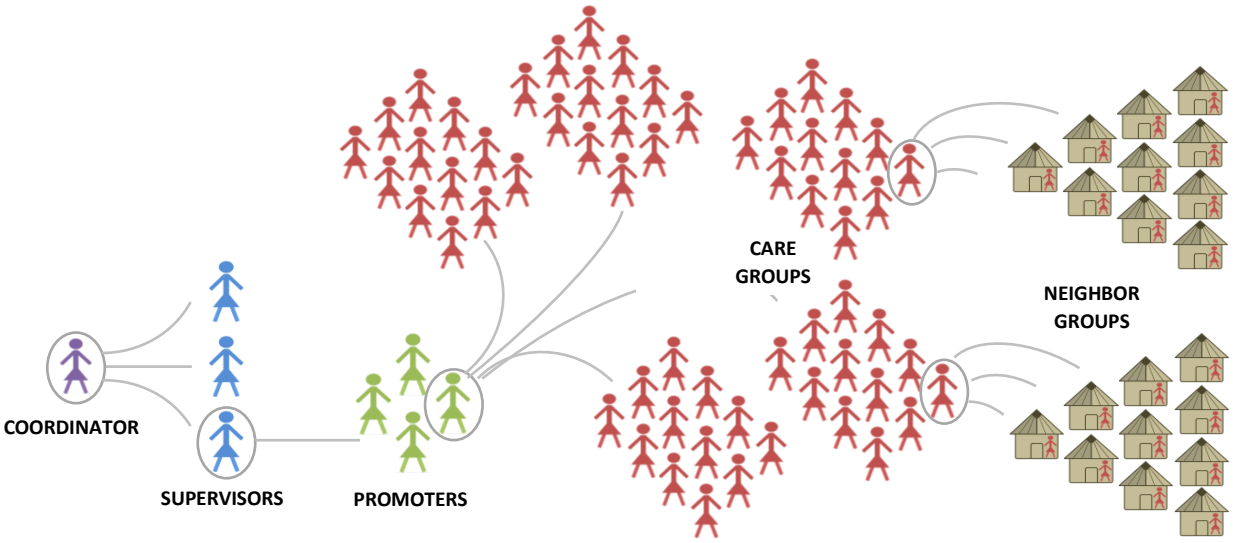
Term	Description
	Group program. Reports to the Project Manager.
Neighbor Group	A group of 10 to 15 women that meets with the selected Care Group Volunteer. The Care Group Volunteer shares new health lessons with them every two weeks as a group or individually (through home visits). (Neighbor Groups are also commonly referred to as a "Cluster.")
Neighbor Women	Women in the Neighbor Group who meet with the Care Group Volunteer once every two weeks to hear a new health lesson. (Neighbor Women are also commonly referred to as "Cluster Members" or "Beneficiary Mothers.")
Pregnant and lactating women	The primary beneficiaries of the Care group approach. The Project Manager should aim to make sure that all or nearly all Pregnant and Lactating Women are part of a Care Group structure (usually as Neighbor Women or Care Group Volunteers).

Care Group Structure

Care Groups create a multiplying effect to equitably reach every beneficiary household through neighbor-to-neighbor peer support using behavior change activities. Peer support not only increases the adoption of new behaviors, but also helps in maintenance of those behaviors, resulting in the creation of new community norms. Care Group Volunteers also provide peer support to one another, develop stronger commitments to implement health activities, and find more creative solutions to challenges through group collaborative effort.

All of these benefits of the Care Group methodology are made possible through the Care Group structure, which efficiently and effectively cascades health promotion messages from the Promoter, to the Care Group Volunteer, and finally to the Neighbor Women through peer education. The diagram below provides an overview of this structure.

The Structure of a Care Group Program



responsible for 3 to 6 Supervisors. A project may hire multiple Coordinators (overseen by a **Project Manager**) if needed to meet the desired coverage.	Each **Supervisor** (paid staff) is responsible for 4 to 6 Promoters.	Each **Promoter** (paid staff) supports 4 to 9 Care Groups.	Each **Care Group** has 10 to 15 Care Group Volunteers that are elected by Neighbor Group members.	lessons with 10 to 15 **Neighbor Women** and their families, known as a **Neighbor Group**. (There is a maximum of 15 Neighbor Women in each Neighbor Group.)
Each Promoter reaches about 500 to 1,200 women.				

Care Group Criteria

This criteria serves to differentiate Care Groups from other women's groups or peer education methodologies, and to ensure the essential 'ingredients' for the successful implementation of the Care Group model are clearly outlined.

The following table lists the 13 essential Care Group criteria, and provides a rationale for each.

Care Group Criteria

Criteria for Care Groups	Rationale
1. The model is based on peer-to-peer health promotion (mother-to-mother for maternal and child health and nutrition behaviors). Care Group Volunteers should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	Care Groups are not the same as Mothers Clubs where mothers are simply educated in a group. An essential element is having women serve as role models and to promote adoption of new practices by their neighbors. There is evidence that "block leaders" (like Care Group Volunteers) can be more effective in promoting adoption of behaviors among their neighbors than others who do not know them as well.[3] Care Group Volunteers who are chosen by their neighbors (or by a consensus of the full complement of community leaders) will be the most dedicated to their jobs, and we believe they will be more effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.[4]
2. The workload of Care Group Volunteers is limited: no more than 15 households per Care Group Volunteer.	In the Care Group model, the number of households per Care Group Volunteer is kept low so that it fits better with the volunteer's available time and allows for fewer financial incentives to be used. In addition, there is evidence that the ideal size for one's "sympathy group"—the group of people to whom you devote the most time—is 10 to 15 people.[5]
3. The Care Group size is limited to 16 members and attendance is monitored.	To allow for participatory learning, the number of Care Group Volunteers in the Care Group should be between 6 and 16 members. As with focus groups, with fewer than 6 members, dialogue is often not as rich and with more than 16, there is often not enough time for everyone to contribute and participate as fully. A low attendance rate (less than 70%) at Care Group meetings is often an indication that something is wrong,

[3]Please see: Burn, S.M. 1991. Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology* 21: 611–629.

[4]Food for the Hungry Operations Researchers studying Care Groups in Sofala, Mozambique found that when mothers chose the Care Group Volunteers to serve them, the Volunteers were 2.7 times more likely to serve for the life of the project (p=0.009).

[5]Please see: Gladwell, M. 2002. *The tipping point.* Boston: Little, Brown and Company, pp. 175–181.

Criteria for Care Groups	Rationale
	either with the teaching methodology or the Promoter's attitude, and monitoring this metric helps the organization to identify problems early in the project.
4. Care Group Volunteer contact with her assigned beneficiary mothers— and Care Group meeting frequency—is monitored and should be at a minimum once a month, preferably twice monthly.	In order to establish trust and regular rapport with the mothers with which the Care Group Volunteer works, we feel it is necessary to have at least monthly contact with them. Care Groups should meet at least once per month. We also believe that overall contact time between the Care Group Volunteer and the mother (and other family members) correlates with behavior change.
5. The plan is to reach 100% of households in the targeted group on at least a monthly basis, and the project attains at least 80% monthly coverage of households within the target group. Coverage is monitored.	In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more likely to happen when there is regular, direct contact with <u>all</u> mothers of young children (rather than reaching only a small proportion of mothers). There is sometimes a combination of group meetings and individual household contacts with beneficiary mothers, but at least some household visits should be included. For group meetings with beneficiary mothers, any mothers that miss meetings should receive a household visit. Household visits are helpful in seeing the home situation and in reaching people other than the mother, such as the grandmother, daughter, or mother-in-law.
6. Care Group Volunteers collect vital events data on pregnancies, births, and death.	Regular collection of vital events data helps Care Group Volunteers to discover pregnancies and births in a timely way and to be attentive to deaths happening in their community (and the causes of those deaths). Reporting on vital health events should be done during Care Group meetings, so that the data can be recorded and discussed by the Care Group members. The point of discussion should be for Care Group members to draw connections between their work and the health events in the

Criteria for Care Groups	Rationale
	community (e.g. what can we do to prevent this kind of death in the future?).
7. The majority of what is promoted through the Care Groups creates behavior change directed towards reduction of mortality and malnutrition.	This requirement was included mainly for advocacy purposes. We want to establish that the Care Group approach can lead to large reductions in child and maternal mortality, morbidity, and malnutrition so that it is adopted in more and more settings. While the cascading or multiplier approach used in Care Groups may be suitable for other purposes (e.g. agriculture education), we suggest that a different term be used for those models (such as "Cascade Groups based on the Care Group model").
8. The Care Group Volunteers use some sort of visual teaching tool (e.g. flipcharts) to do health promotion at the household level.	The provision of visual teaching tools to Care Group Volunteers helps to guide the health promotion that they do, gives them more credibility in the households and communities that they serve, and helps to keep them "on message" during health promotion. The visual nature of the teaching tool also helps reinforce the message by allowing mothers both hear it and see it.
9. Participatory methods of behavior change communication are used in the Care Groups with the Care Group Volunteers and by the volunteers when doing health promotion at the household or small-group level.	Principles of adult education should be applied in Care Groups and by Care Group Volunteers since they have been proven to be more effective than lecture and more formal methods when teaching adults.
10. The Care Group instructional time (when a Promoter teaches Care Group Volunteers) is no more than two hours per meeting.	Care Group Volunteers are volunteers and, as such, their time needs to be respected. Limiting the Care Group meeting time to one to two hours helps improve attendance and limits their requests for financial compensation for their time.
11. Supervision of Promoters and at least one of the Care Group Volunteers occurs at least monthly.	For Promoters and Care Group Volunteers to be effective, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of Care Group Volunteers, the usual pattern is for the Promoter to supervise through direct observation at least one Care Group Volunteer following the Care Group meeting.

Criteria for Care Groups	Rationale
12. All of a Care Group Volunteer's beneficiaries should live within a distance that facilitates frequent home visitation and all Care Group Volunteers should live less than a one hour walk from the Promoter meeting place.	It is preferable that the Care Group Volunteer not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. In addition, this proximity makes it more likely that she will have a prior relationship with the people that she is serving. Before starting up Care Groups, the population density of an area should be assessed. If an area is so sparsely populated that a Care Group volunteer needs to travel more than 45 minutes to meet with the majority of her beneficiary mothers, then the Care Group strategy may not be the most appropriate model.
13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	An important part of this model is fostering respect for women. Implementers need to make this an explicit part of the project, encourage these values among project staff, and ideally measure whether Care Group Volunteers are sensing this respect.

Establishing Care Groups

This section details the steps to establish Care Groups. The specific means to accomplish each step will necessarily vary on the context of the project and preferences of project staff. Regardless of the specific methods used, the following two key tenants must be followed when forming Care Groups:

- Care Groups are an equitable approach and aim to have 100% of all beneficiaries (women who are pregnant, lactating, or mothers of young children) included in Care Group activities.
- Each Care Group Volunteer's assigned beneficiary households should be as close together as possible so that regular visitation is not hindered. This also makes it more likely that the Care Group Volunteer will have prior relationships with the people they serve, which will help to foster behavior change.

Identifying Beneficiary Households

A beneficiary household is a household with at least one pregnant or lactating woman or a mother of children under two years of age (some Care Group projects may also include mothers of children under five; or even all women of reproductive age).

At the start of the project, beneficiary households are identified through a community census. There are two ways to conduct the census:

1. Conducting door-to-door visits at each household in the village.
2. Meeting with community leaders who are reliably able to identify all households with women who are pregnant, lactating, or mothers of young children. Note that it is important to verify the census information provided by the community leaders for accuracy. It is more difficult to tell how best to form neighbor groups of households using this method.

Once all the beneficiary households are identified in a village, a list of all beneficiary households should be generated, as per the table below. Depending on the total number of beneficiary households identified in the village, neighbor groups of 10 to 15 beneficiary households should be formed, based on the geographic location of the household.

Community Census List

Number	Mother's Name	Pregnant (Yes/No)	Household has a child under 2? (Yes/No)	Community Area	Temporary Group #	Elected Care Group Volunteer
1	Leena Samuel	Yes	No	Kivo	1	
2	Niragira Regine	No	Yes	Kivo	1	
3	Nicole Nduwayo	No	Yes	Kivo	1	
4	Nzoyisenga Claudine	Yes	No	Kivo	2	
5	Alice Nzomukunda	No	Yes	Kivo	2	✓ A

Selection of Care Group Volunteers

Once the neighbor groups have been formed based on their geographic proximity, gather the neighbor women together to select the Care Group Volunteer. Review the job description of a Care Group Volunteer (see box) with the women, and ask them to elect a Care Group Volunteer from among the group.

At minimum, a Care Group Volunteer must be willing to work as a volunteer and have a desire to serve her neighbors and be willing to adopt the behaviors promoted by the project and model positive health and nutrition practices. Projects may choose to include other criteria for

The Care Group Volunteer job description includes the following responsibilities:

- Meets with her neighbor women at least once per month to promote behavior change
- Visits each neighbor woman at home once per month (according to the need and the relevance of the behavior) to negotiate behavior change
- Monitors and reports vital events that have occurred in the community, such as births, deaths, and severe illness
- Mobilizes neighbor women to participate in community activities that will benefit their families, such as immunization campaigns, food distribution, or latrine construction
- Attends Care Group meetings facilitated by the Promoter and reports the number of neighbor women she reached
- Reports problems that cannot be solved at the household level to local leadership, and requests support and collaboration from the Promoter
- Models the health, nutrition, and sanitation behaviors she teaches the neighbor women

selecting Care Group Volunteers, such as basic literacy or being a respected member of the community.

Once the Care Group Volunteer is selected, place a check mark next to the mother's name on the village beneficiary household listing, as shown in the Community Census List example above.

An Alternative Approach to Identifying Beneficiary Households and Electing Care Group Volunteers

If community participation is high, community leaders may call all pregnant and lactating women and mothers of young children to a central meeting place on a particular day. If a woman is ill or cannot attend, she could appoint someone to represent her (and to take her prenatal visit card or child's health card to the community gathering). Women could be asked to group themselves first into neighborhoods, then into smaller neighbor groups, and elect their Care Group Volunteer from this self-organization.

Formation of Care Groups

Once all of the Care Group Volunteers have been selected, Care Groups are formed based on the geographic proximity of the Care Group Volunteers. Just as each Care Group Volunteer should not have to walk long distances to conduct household visits to her neighbor women; she also should not have to travel far to attend her Care Group meetings with the Promoter. Therefore, Care Groups should consist of Care Group Volunteers who live within geographic proximity to each other. Each Care Group should have a minimum of six and a maximum of 16 Care Group Volunteers, to allow for participatory learning. As with focus groups, with fewer than six members, dialogue is often not as rich and with more than 16 participants, there is often not enough time for everyone to contribute and participate as fully.

Selection of Promoters

The best Care Group Promoters already live in the communities where they will work. Ideally, Promoters are identified and hired before the beneficiary household identification process, as they may play a key role in facilitating the census and Care Group Volunteer selection process.

While each project will determine its own criteria for hiring Promoters, the following minimum criteria will ensure the Promoter will be able to effectively carry out his/her responsibilities (see box):

- Able to speak, read, and write in the local language
- Basic math skills (e.g. addition, subtraction)
- Physically able to move around the project area
- Able to participate in trainings and meetings with project staff

- Able to speak confidently in front of groups and facilitate discussion
- Respectful and considerate of others

The Promoter job description includes the following responsibilities:

- Facilitates Care Group meetings with his/her Care Group Volunteers every two weeks following the lesson plans in the educational materials provided
- Supervises each Care Group Volunteer at least quarterly by accompanying them on home visits and observing them leading group meetings
- Completes monthly reports based on the Care Group Volunteer registers
- Coordinates local-level activities and maintains cooperation with other community-level institutions, such as the village council, churches, and schools
- Models the health, nutrition and sanitation behaviors he/she teaches Care Group Volunteers in his/her own homes

Implementation of Care Groups

Formative Research and Development of Behavior Change Modules

Each Care Group project aims to promote healthy practices through behavior change modules. Each module is related to a specific theme, such as healthy pregnancy and delivery, infant and young child feeding, or malaria. Each module is then divided into lessons focusing on one or two specific behaviors that are taught at each meeting.

Most Care Group projects have four to six modules, with a total of approximately 25 lessons. If a new lesson is introduced every two weeks, it would take 50 weeks (one year) to cover all of the lessons. Alternately, a project could elect to only cover one lesson per month, which would require just over two years (25 months) to cover all the lessons. Often, there are holidays and other community events that will disrupt the project, which will lead to implementation taking longer than planned. It is therefore important to develop a loose schedule of module implementation at the onset of the project.

Each lesson is accompanied by a visual aid to enable participatory learning. Typically, a flip chart is used with an image on the front that tells a story with a discussion guide and key talking points on the back for the Care Group Volunteers' use.

Many non-governmental organizations choose to use modules and lesson plans that have already been developed and adapt them to their specific cultural context. Other projects might use or adapt curricula recommended by the Ministry of Health. Project staff may also develop their own modules and lessons.

It is recommended that visual aids and lessons are informed by formative research to better understand barriers to behavior change. For example, if mothers say that their own mothers and mothers-in-law do not approve of exclusive breastfeeding, then the flip chart picture could show a grandmother helping her daughter (the child's mother) to breastfeed or telling her daughter not to give any water to an infant. One formative research method commonly used in Care Group projects is Barrier Analysis, a

Sample Care Group Module

- Module Title: Care of Pregnant Women and Newborns
- Lesson 1: Antenatal Care and Health Center Births
- Lesson 2: Maternal Nutrition and Anemia Prevention
- Lesson 3: Iodized Salt and Iron-Rich Foods
- Lesson 4: Hand Washing with Soap or Ash
- Lesson 5: Creation of Household Hand Washing Stations
- Lesson 6: Preventing Malaria in Pregnant Women
- Lesson 7: Preparing for Birth and Delivery
- Lesson 8: Immediate Breastfeeding
- Lesson 9: Newborn Care Practices

rapid assessment tool for community health and development projects, which can be conducted to identify behavioral determinants associated with a particular behavior.[6] Other formative research approaches may include in-depth focus groups or positive deviance studies.

Formative research and the development of modules may be conducted before or even at the same time as other initial Care Group activities, such as the household census and election of Care Group Volunteers. Implementers should plan ahead to ensure that modules are finalized and printed once Care Group Volunteers have been elected and Care Groups have been formed, so that the momentum is not lost from the time Care Groups are formed to beginning activities using the modules.

Training of Promoters

At the beginning of each module (approximately every three to four months, depending on the length of the module), supervisors should facilitate an intensive training for Promoters that covers each lesson. This training usually lasts four to six days, and includes the technical basis for the module, training on each of the lesson plans, and several days of coaching and practicing.

Depending on the level of expertise the supervisor has on the topics covered in the module, it may be helpful to invite members of the Ministry of Health to co-facilitate the training and/or be available to answer questions that may arise. The involvement of Ministry of Health staff is an excellent way to promote collaboration between the government health system and Care Groups. It also equips health facility staff with knowledge and tools to promote the same behavior change practices when community members seek health facility services.

In larger Care Group projects, the distances required to bring all Promoters together may be prohibitive, or there may be too many Promoters to run an effective training. (It is not recommended to train more than 25 people at one time.) In these cases, Promoters should be trained in smaller groups based on geographic region.

In addition to ensuring the Promoters have a solid understanding of the content of the modules, supervisors and other training facilitators should model the participatory nature of the training. To the extent possible, the training of Promoters should include each of the nine steps of the Care Group meeting (described in the section below); with a particular emphasis on brainstorming potential activities, discussing barriers to behavior change, as well as practicing and coaching.

[6]For more information about Barrier Analysis, please see: Kittle, B. 2013. A Practical Guide to Conducting a Barrier Analysis. New York, NY: Helen Keller International. Available at: www.fsnnetwork.org/practical-guide-conducting-barrier-analysis

Care Group Meetings

The Promoter facilitates two Care Group meetings per month. Ideally, the Care Group meetings follow a set schedule, and are at a convenient time for both the Promoters and Care Group Volunteers. The Care Group meeting location should be within a maximum of one hour's walk for all participants.[7] The Care Group meeting should last no more than two hours: Care Group Volunteers are volunteers and, as such, their time needs to be respected. Limiting the Care Group meeting time to one to two hours helps improve attendance and limits requests for financial compensation.

Each Care Group meeting will follow a similar structure. The specific sequence of the meeting may vary by project, but each of the following steps should be included:

1. **Lesson Objectives:** Each lesson should focus on one or two doable behaviors. These are the behaviors that the project expects the Care Group Volunteers and neighbor women to practice based on the key messages in the flip chart.
2. **Game or Song:** Each lesson should start with a game or song. This helps Care Group Volunteers feel relaxed and builds a sense of safety. When women feel safe they are more likely to share their experiences, talk openly about their struggles, and consider trying new practices at home.
3. **Attendance and Trouble-Shooting:** The Promoter notes the Care Group Volunteers present at the meeting and records attendance. The Promoter asks if there are any vital events to report (birth, deaths, or new pregnancies) and collects Care Group Volunteers' activity reports for the month if applicable. The Promoter will ask about and discuss any problems the Care Group Volunteers have faced in teaching the previous lesson, and will ask the Care Group Volunteers if they were able to try out the behaviors committed to in the previous meeting. This is an important opportunity to address any barriers that come up in practicing a new behavior.
4. **Behavior Change Promotion through Pictures:** The Promoter should then use the flip chart picture to teach about the behavior. Discussion questions should be used to find out the current practices by the women in the group.
5. **Activity (if possible):** People usually do not change their behavior just by being told to do so! Behavior change will be much more likely if women are able to try out the behavior in a safe environment. For example, if the lesson is on insecticide-treated bed nets (ITNs) use, women should practice hanging an ITN. If the behavior is on dietary diversity, a simple cooking demonstration could be arranged. The Promoter is responsible for organizing

[7] If Care Group Volunteers are walking more than one hour to attend Care Group meetings, Promoters should alert their supervisor. The Supervisor should then review the coverage strategy and adjust it to allow for smaller Care Groups, composed of Care Group Volunteers who live closer together.

materials for each lesson's activity. Materials may be brought by Care Group Volunteer from their own homes to create a 'real life' situation. An activity may not be possible for all behaviors.

6. **Discuss Potential Barriers and Solutions**: When Care Group Volunteers discuss barriers during each lesson, they have to really imagine doing the behavior within their household context. Once all of the barriers are discussed, the Promoter should engage all participants in identifying ways to overcome the barriers mentioned. It is not the responsibility of the Promoter to offer solutions. Brainstorming solutions is a group responsibility and will help empower Care Group Volunteers to become effective problem solvers.
7. **Practice and Coach**: Each Care Group Volunteer should practice teaching the lesson to another volunteer. The Promoters should observe and give advice when needed. This helps the Care Group Volunteers become familiar and comfortable with the flip charts and the messages.
8. **Request a Commitment to Try the New Behavior:** Studies have shown that when someone promises to do something they are much more likely to do it. The Promoter should ask each Care Group Volunteer to commit to trying out the new behavior herself, before teaching others.

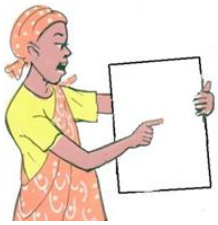
Facilitation Cues

1. Objectives

2. Game or song

3. Attendance and troubleshooting

4. Behavior change promotion through pictures



5. Activity

6. Discuss barriers and solutions

7. Practice and Coach

8. Ask for a commitment

Household Visits and Group Meetings with Neighbor Women

Each neighbor woman should have at least one contact per month with their Care Group Volunteer. This may be done through either a household visit or small group meeting with other neighbor women in her neighbor group.

Immediately following the Care Group meeting, the Care Group Volunteer should make contact with each of her assigned neighbor women through a household visit or group meeting. There may be a combination of group meetings and individual home visits with neighbor women. Any neighbor women that miss a group meeting should receive a household visit from the Care Group volunteer. Household visits are also helpful in seeing the home situation and in reaching people other than the mother, such as the grandmother, husband, or mother-in-law.

Household visits and group meetings should follow the same general structure as those in the Care Group meeting, with the following adaptations:

1. **Lesson Objectives:** Tell the neighbor woman and her household members the topic of the lesson for the visit.
2. **Game or song:** If conducting a group meeting, the Care Group Volunteer may facilitate a game or song. At home visits, creating a safe and comfortable atmosphere with a little relaxed conversation and greeting everyone in the family might be more beneficial.
3. **Reporting and Troubleshooting:** The Care Group Volunteer records the date of the visit or meeting, and inquiries about any vital events in the previous month. The Care Group Volunteer asks the neighbor woman if she was able to try out the behaviors committed to in the previous meeting. This is an important opportunity to address any barriers that come up in practicing a new behavior.
4. **Behavior Change Promotion through Pictures**: The Care Group Volunteer should then use the flip chart picture to teach about the behavior. In a group setting, discussion questions should be used to find out the current practices by the mothers in the group. If at a household visit, the Care Group Volunteer may wish to involve other family members present (such as a husband, mother-in-law, etc.) in the lesson.
5. **Activity:** If possible, the Care Group Volunteer should demonstrate and help the neighbor women practice the new behavior.
6. **Discuss Potential Barriers and Solutions**: This step should always be carried out, as it can be a very important discussion to have with influential household members for certain behaviors where influencers have a big role in determining whether the behavior is practiced or not.
7. **Request a Commitment to try out the New Behavior**: The commitment can be to take a small action, or first step, towards adopting the new behavior, such as “I will tell my husband what I have learned and talk with him about building a latrine.” The neighbor woman does not have to promise to build the latrine this week.

Supervising Care Group Activities

Although the Care Group approach has been proven to be very effective as a behavior change strategy, if it is not executed with a high level of quality, it will not produce the desired results. Also, in monitoring implementation the focus tends to be on quantity (number of meetings held and how many people attended) rather than quality. How well Care Group activities are implemented is therefore critical to monitor through consistent supervision.

Supportive Supervision

Supportive supervision is an on-going process designed to mentor and coach a worker so that he/she gains the independence, self-confidence, and skills needed to effectively accomplish the work. Supportive supervision is essential in Care Group projects to provide support to Care Group actors and ensure the approach is being implemented as intended.

Supportive supervision of Care Group activities happens on at least two levels: the supervision of Care Group Volunteers by Promoters; and the supervision of Promoters by their Supervisors.

Supervision of Care Group Volunteers by Promoters

The Promoter should supervise at least one Care Group Volunteer from each of his/her Care Groups every month. During the supervision visit, the Promoter should:

- Observe the Care Group Volunteer facilitating a household visit or small group meeting. Ideally, the Promoter will use a Quality Improvement Verification Checklist (QVIC; described below), which includes the key steps of the Care Group meeting against which the Promoter can assess to what extent each step was completed.
- Return to the Care Group Volunteer's home to give feedback.
- Assess the Care Group Volunteer's home and practices to see if the Care Group Volunteer is following the practices that she is promoting. The Care Group Volunteer is the 'model' mother in her community. If she is not following the practices she is teaching, the Promoter should help the Care Group Volunteer overcome any barriers.
- Review the Care Group Volunteer's register for completeness and accuracy.
- Ask about any problems the Care Group Volunteer is facing and trouble-shoot accordingly; support and encourage the Care Group Volunteer, and thank her for her important work.

Supervision of Promoters by Project Staff

The ability of the Promoter to facilitate Care Group activities is the linchpin of the Care Group approach. Promoters require supportive supervision by project staff supervisors to ensure they are implementing the approach with high levels of quality and fidelity to the model.

Ideally, each Promoter should receive a supervision visit once per month. Almost all of the Promoter's work is done in the community, so supervision must take place in the community. Simply meeting with Promoters during trainings and reviewing reports is not considered supervision.

During the supervision visit, the supervisor should:

- Observe the Promoter facilitating a Care Group meeting, preferably using a QIVC (described below)
- Talk to three to five Care Group Volunteers to assess their participation level and interest in the in the program, and the quality and consistency of the Promoters' work.
- If possible, talk to some of the neighbor women to assess their participation level, their interest in the program, and the quality and consistency of the Promoters' work.
- Review the Promoter's reports for completeness and accuracy
- Assess whether the Promoter's materials (registers, teaching materials) are kept in a safe, clean place
- Ask about any problems the Promoter is facing and trouble-shoot accordingly; support and encourage the Promoter, and thank them for their important work.

Quality Improvement Verification Checklists (QVIC)[8]

Example QIVCs and supportive supervision checklists are included in the Care Group Training manual

A key tool used during supportive supervision is a QIVC. As the name suggests, this is a checklist of the key elements to be included in each Care Group meeting or household visit. For example, the QIVC may include questions on whether the correct methodology was used during the education session ('did the Promoter ask participants if there were any barriers that might prevent them from adopting the behavior?') and the facilitation skills ('did the Promoter speak slowly and clearly?').

Each question on the form has a yes or no answer. After reading the question, the supervisor should decide if the answer is 'yes' or 'no' and mark the corresponding box. The supervisor should complete the checklist only after the event is completed, not during. This is done so the supervisor completing the QIVC may be attentive during the event being evaluated, and not distracted by filling out the form.

Once completed, the number of 'yes' ticks may be tallied, in order to give an overall percentage score to the person being supervised. This score may also be included in the project's QIVC monitoring system, in order to track improvements in scores over time. The project could also choose not to quantify the QIVC score, but rather to use the checklist as a basis to give feedback

[8]Readers interested in more information on the Quality Improvement Verification Checklists can refer to the Recommendations for Further Reading section on page 29.

– especially positive reinforcement – to the Promoter or Care Group Volunteer being supervised.

Feedback during all supportive supervision visits should be provided in a private location, and should emphasize positive points. Any areas for improvement should be communicated gently, so the person being supervised does not feel shameful or discouraged. Remember, Care Group Volunteers (and in some projects, Promoters) are volunteers – not employees, and all project staff, whether paid or volunteer, should be treated with respect.

Monitoring and Evaluation

Monitoring and Reporting

The successful implementation of Care Groups relies on effective and timely reporting of Care Group activities. This reporting enables the project to monitor attendance at Care Group meetings and coverage of household visits and neighbor group meetings, which are the two most important aspects of the Care Group approach. If Care Group Volunteers are not attending the Care Group meetings, and are not visiting their neighbor women, the project will not be successful.

In addition to monitoring Care Group activities, data is also reported on vital events for all members of Neighbor Groups and Care Groups, allowing the project to track maternal, child, and infant mortality (data that would otherwise be expensive and time intensive to collect). Depending on donor requirements, the project may also collect data on other project activities or indicators through the Care Group reporting structure, such as attendance at growth monitoring sessions, immunization coverage, or incidence of childhood illness.

Registers

To ensure timely and accurate reporting, Care Groups projects utilize registers to capture and share key data. The main registers are:

- Neighbor Group register (maintained by the Care Group Volunteer)
- Care Group register (maintained by the Promoter)

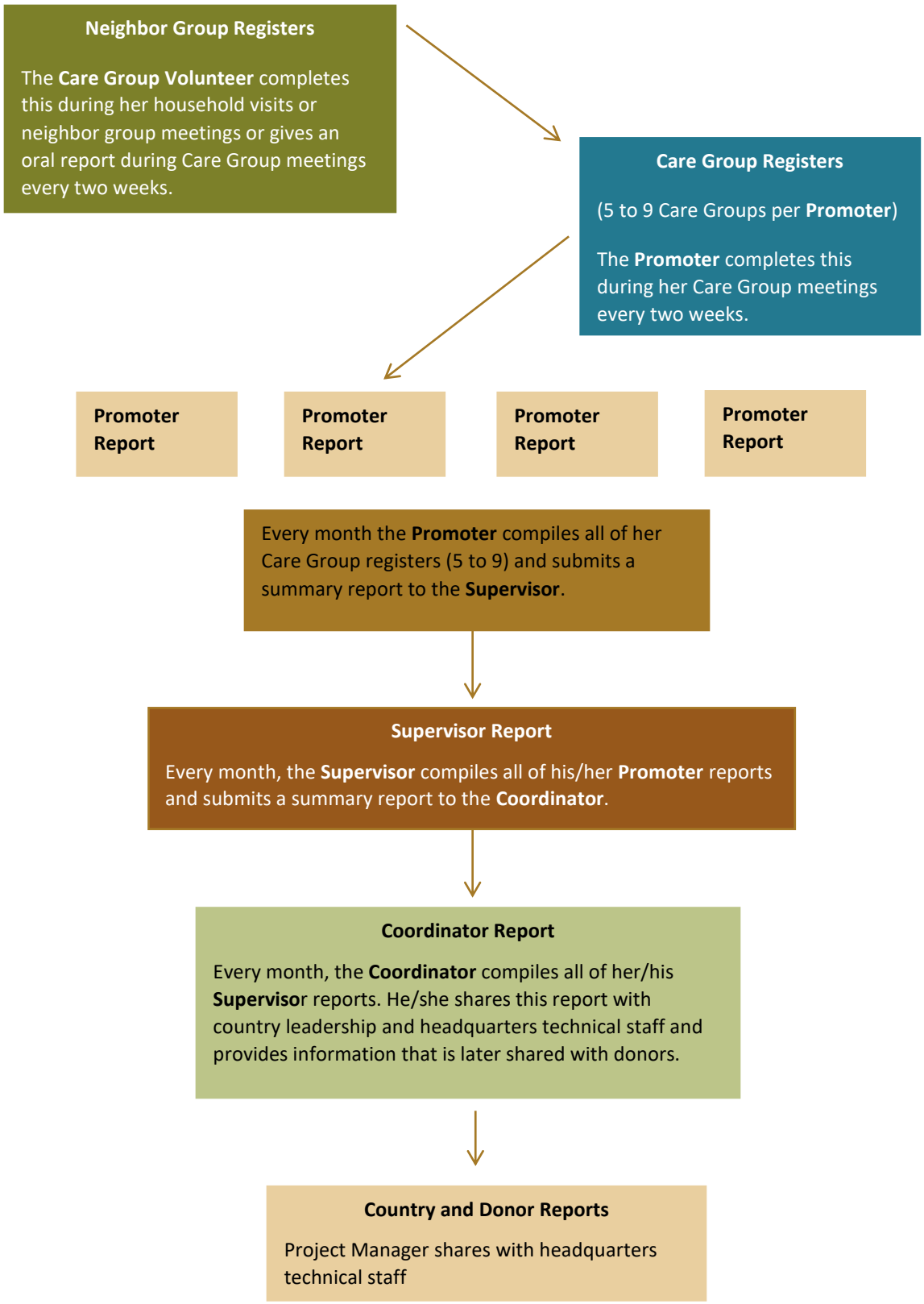
These registers are very similar to one another and collect four types of information from the Neighbor Groups and Care Groups:

- Date when the members joined (registration information)
- Attendance at group meetings or home visits
- Vital events of group members (maternal deaths, deaths of children under 2 and child births)
- Lessons in the Care Group curriculum that have been covered

Examples of these registers are included in *Care Groups: A Training Manual for Program Design and Implementation*. As noted above, some Care Group projects adapt these registers to collect more information. The registers should be as simple as possible. Adding additional fields to the registers will require Care Group Volunteers and Promoters to spend more time filling out the registers during their meetings every two weeks, which may take away time from teaching the curriculum. Detailed, complicated registers may also lead to errors in reporting or a temptation to falsify information if the Care Group Volunteers and Promoters find the registers too burdensome to fill out each meeting.

Reporting is typically done at the second Care Group meeting of each month; so that Promoters may submit their summary reports to their supervisors at the end of each month. The diagram on the next page illustrates the flow of information through a Care Group Management Information System.

The Flow of Information through a Care Group Management System



Key Performance Indicators

Based on the data collected through the registers, a number of indicators may be calculated to assess the ongoing functionality of the Care Groups. These may include the following:

- The percentage of Care Groups that met twice in the previous month.
- The percentage of Care Groups that had at least 80% Care Group Volunteer attendance at Care Group meetings in the previous month.
- The percentage of neighbor women that were visited by a Care Group Volunteer (through either a household visit or group meeting) in the previous month.

Evaluation

While the Care Group reporting data will provide information on Care Group functionality, the uptake of specific healthy practices promoted by the project is the ultimate indication of the project's success. To assess the coverage of these practices, a population survey (such as a standard Knowledge, Practice, and Coverage (KPC) survey) should be conducted at baseline and endline, and, if possible, at midterm. In addition, Mini-KPC surveys can be conducted every four to six months for key behavioral indicators.

Sequencing Care Group Activities

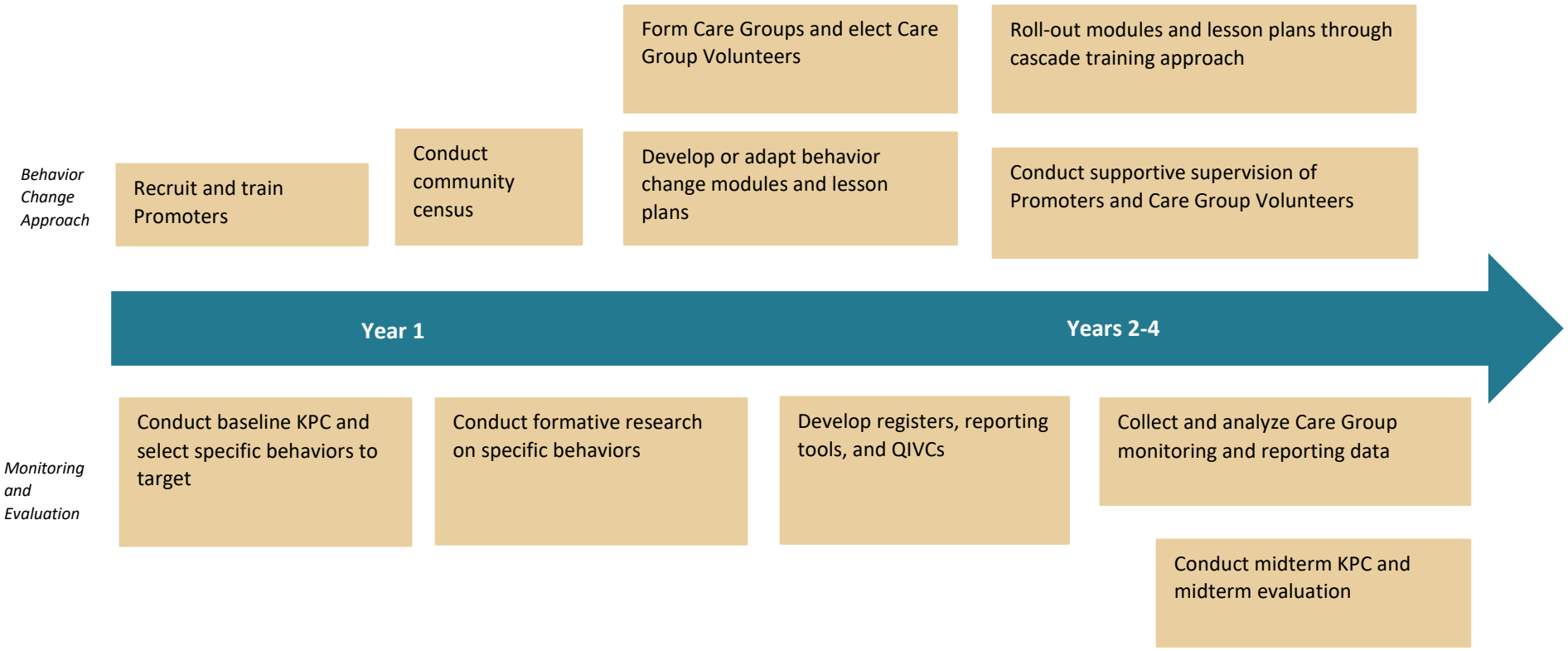
Most Care Groups are implemented within a five-year project cycle. While the core Care Group activities – Care Group meetings, household visitation, reporting – will be implemented for the majority of the project, there are several tasks that must be completed in the first year to lay the foundation for successful implementation. These include:

- Conducting the baseline survey and formative research
- Development of modules, lesson plans, and reporting tools
- Conducting the census and electing Care Group Volunteers
- Training all actors in the Care Group approach

Often, new Care Group implementers are surprised at the number of tasks required to establish Care Groups, and may not allow adequate start-up time in the first year of the project for their completion. The timeline below provides a suggestion on how Care Group activities may be sequenced, especially the critical start-up activities in the first year. Note that several activities may be conducted concurrently. For example, while some project staff are engaged in leading the census and establishing Care Groups in the communities, other staff members may work on developing the modules and lesson plans.

As shown in the timeline, it is reasonable to expect that the actual Care Groups will not formally start meeting until the second year of the project.

Care Group Planning Timeline



Conclusion

This reference guide is intended to be a brief overview for practitioners interested in implementing a Care Groups model in their programs. This brief guide is based on this resource, *Care Groups: A Training Manual for Program Design and Implementation*, and is intended to serve as a supplemental resource. We endeavor to systematize the Care Groups approach in order to maximize its effectiveness. The guide has tried to meet this objective by clearly defining the roles, the essential criteria, the key roles and terms, as well as the guiding structure of the standard Care Group approach. In addition, we have demonstrated how to best establish, implement, and supervise activities. Lastly, we have touched on the importance of monitoring and evaluating key indicators to ensure that the program is performing at the highest possible level. By providing a standard approach and laying out the best practices as a guide, we can further the global conversation about the efficacy of the Care Groups model. As innovations and variations are tested and validated, we hope to incorporate any lessons learned into future materials.

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Recommendations for Further Reading

Davis, Thomas. 2012. *Quality Improvement & Verification Checklists: Online Training Module, Training Files, Slides, QIVCs, etc.* Washington, DC: Technical and Operational Performance Support Program.

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For additional information or for more ways to get more involved please visit:

- Care Groups Forward Interest Group, caregroupinfo.org
- The Food Security and Nutrition Network (FSN) Network, www.fsnnetwork.org